Filing at a Glance

Company:	Security Life of Denver Insurance Company
Product Name:	165949 Apps
State:	Arkansas
TOI:	L08 Life - Other
Sub-TOI:	L08.000 Life - Other
Filing Type:	Form
Date Submitted:	12/27/2012
SERFF Tr Num:	INGD-128729544
SERFF Status:	Closed-Approved-Closed
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	165949 APPS
Implementation Date Requested:	On Approval
Author(s):	Wendy Paquin, Terry Stumpf, Jackie Williams, Tonya Gallatin
Reviewer(s):	Linda Bird (primary)
Disposition Date:	01/24/2013
Disposition Status:	Approved-Closed
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *Security Life of Denver Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *165949 Apps*
Project Name/Number: *165949 Apps/165949 Apps*

General Information

Project Name: 165949 Apps
Project Number: 165949 Apps
Requested Filing Mode: Review & Approval

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: Wendy Paquin

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: This filing was submitted to Colorado, our state of domicile, simultaneously.
Market Type: Individual
Individual Market Type:
Filing Status Changed: 01/24/2013
State Status Changed: 01/04/2013
Created By: Wendy Paquin
Corresponding Filing Tracking Number:

Filing Description:
Insurance Commissioner
Department of Insurance
Compliance Life & Health
1200 West Third Street
Little Rock, Arkansas 72201-1904

Re: Security Life of Denver Insurance Company
NAIC #68713 FEIN #84-0499703

Form Numbers:
165949 Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance
165952 Executive Benefits Individual Application for Employer-Sponsored Guaranteed Issue Life Insurance
165956 Executive Benefits Application for Simplified Issue Life Insurance
165967 Executive Benefits Temporary Insurance Receipt Guaranteed Issue
165976 Executive Benefits Consent To Be Insured

Attention Policy Form Approval Division:

We submit the above referenced forms for your review and approval. The forms do not replace any previously approved forms.The forms do not contain any unusual or controversial items from the standpoint of industry standards.

We are exempt from filing in Colorado, our state of domicile, pursuant to Colorado Bulletin B-4.1 (May 8, 2007).

The information bracketed in the forms is subject to change.

These forms will be available both in a printed and electronic format. When presented electronically for completion by the customer or agent the actual wording of the statements and questions will not change but based on responses, they may appear in a slightly different order. Logic will be built into the system to allow only applicable information and questions to appear to the applicant. The electronic format application presented to the customer for signature will appear on screen as a pdf of the filed application form containing all information completed by the customer, in appearance identical to the printed version. If an electronic signature will be used with an application, it will be obtained in compliance with applicable State and Federal law.

State: *Arkansas* **Filing Company:** *Security Life of Denver Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *165949 Apps*
Project Name/Number: *165949 Apps/165949 Apps*

Application 165949 - Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance - is used for a life insurance plan that is sponsored and owned by either the employer or a trust. The insurance is paid for by the employer. The form will be completed by the employer or trustee and will include a census and Executive Benefits Consent to Be Insured Form 165967 for each employee included in the plan. Application 165949 will be used for both general and variable account products.

Application 165952 - Executive Benefits Individual Application for Employer-Sponsored Guaranteed Issue Life Insurance - will be completed by the employee when the insurance will be owned by the employee but paid and sponsored by the employer. This form will be used for both general and variable account products.

Application 165956 - Executive Benefits Application for Simplified Issue Life Insurance - will be completed by an employee when applying for either an employee or employer-owned policy. The insurance is sponsored and paid for by the employer and is used when the amount of insurance/age of the employee requires more complete underwriting. It will be used for both general and variable account products.

Form 165967- Executive Benefits Temporary Insurance Receipt Guaranteed Issue - will be used when premiums are received from the employer in connection with 165949 and 165952. This provides a limited amount of life insurance for a short time while the company reviews the applications for insurance. This form will be used for Guaranteed Issue general and variable account products.

Form 165976 – Executive Benefits Consent To Be Insured - will be used when the employer applies for life insurance on an employee. This form will be used for both general and variable account products.

The following previously approved form(s) will be marketed with the submitted policy form (approval date(s) provided):

1176-08/08 - Flexible Premium Adjustable Universal Life Insurance Policy - 07/30/2008
1177-10/08 - Flexible Premium Adjustable Universal Life Insurance Policy - 09/08/2008
1180-12/09 - Flexible Premium Adjustable Universal Life Insurance Policy - 11/03/2009
1186-09/12 - Flexible Premium Adjustable Universal Life Insurance Policy - 06/18/2012
2516(VUL)-09/07 Flexible Premium Adjustable Variable Universal Life Insurance Policy - 07/19/2007
2517(VUL)-03/08 Flexible Premium Adjustable Variable Universal Life Insurance Policy - 02/05/2008
2518(VUL)-06/08 Flexible Premium Adjustable Variable Universal Life Insurance Policy - 04/24/2008

Unless otherwise informed, we reserve the right to alter the layout of the enclosed forms, including sequential ordering of the sections, color, and type font and size, and any changes necessary to correct typographical errors or comply with your state requirements, but we will only do so if such changes are within the allowable parameters or requirements set forth in your statutes.

To the best of our knowledge, the forms comply with the laws and regulations of your state.

Sincerely,

Wendy Paquin, FLMI, CLU
Senior Contract Analyst
(612) 342-3595
(612) 342-7531 (fax)
wendy.paquin@us.ing.com

State: *Arkansas*
Filing Company: *Security Life of Denver Insurance Company*
TOI/Sub-TOI: *L08 Life - Other/L08.000 Life - Other*
Product Name: *165949 Apps*
Project Name/Number: *165949 Apps/165949 Apps*

Company and Contact

Filing Contact Information

Wendy Paquin,
20 Washington Ave South
Minneapolis, MN 55401

wendy.paquin@us.ing.com
612-342-3595 [Phone]
612-342-7531 [FAX]

Filing Company Information

Security Life of Denver Insurance Company
20 Washington Avenue South
Mail Stop 1217
Minneapolis, MN 55401
(800) 448-9839 ext. 2247670[Phone]

CoCode: 68713
Group Code: 229
Group Name:
FEIN Number: 84-0499703

State of Domicile: Colorado
Company Type: Life Insurance
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$250.00
Retaliatory?	No
Fee Explanation:	5 forms x $50 per form = $250
Per Company:	No

Company	Amount	Date Processed	Transaction #
Security Life of Denver Insurance Company	$250.00	12/27/2012	66043738

SERFF Tracking #:	*INGD-128729544*	***State Tracking #:***		***Company Tracking #:***	*165949 APPS*

State:	*Arkansas*	***Filing Company:***	*Security Life of Denver Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*165949 Apps*		
Project Name/Number:	*165949 Apps/165949 Apps*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	01/24/2013	01/24/2013
Approved-Closed	Linda Bird	01/04/2013	01/04/2013

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance	Wendy Paquin	01/24/2013	01/24/2013

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Request to reopen	Note To Filer	Linda Bird	01/24/2013	01/24/2013
Request to Reopn	Note To Reviewer	Wendy Paquin	01/24/2013	01/24/2013

SERFF Tracking #:	*INGD-128729544*	***State Tracking #:***		***Company Tracking #:***	*165949 APPS*

State:	*Arkansas*	***Filing Company:***	*Security Life of Denver Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*165949 Apps*		
Project Name/Number:	*165949 Apps/165949 Apps*		

Disposition

Disposition Date: 01/24/2013
Implementation Date:
Status: Approved-Closed

Comment: Company has made corrections on the original submission approved on 01/04/2013.

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance		Yes
Form (revised)	Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance		Yes
Form	Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance	Replaced	Yes
Form	Executive Benefits Application for Simplified Issue Life Insurance		Yes
Form	Executive Benefits Temporary Insurance Receipt Guaranteed Issue		Yes
Form	Executive Benefits Consent To Be Insured		Yes

SERFF Tracking #:	*INGD-128729544*	***State Tracking #:***		***Company Tracking #:***	*165949 APPS*

State:	*Arkansas*	***Filing Company:***	*Security Life of Denver Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*165949 Apps*		
Project Name/Number:	*165949 Apps/165949 Apps*		

Disposition

Disposition Date: 01/04/2013
Implementation Date:
Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Statement of Variability		Yes
Form	Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance		Yes
Form (revised)	Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance		Yes
Form	Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance	Replaced	Yes
Form	Executive Benefits Application for Simplified Issue Life Insurance		Yes
Form	Executive Benefits Temporary Insurance Receipt Guaranteed Issue		Yes
Form	Executive Benefits Consent To Be Insured		Yes

SERFF Tracking #:	*INGD-128729544*	***State Tracking #:***		***Company Tracking #:***	*165949 APPS*

State:	*Arkansas*	***Filing Company:***	*Security Life of Denver Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*165949 Apps*		
Project Name/Number:	*165949 Apps/165949 Apps*		

Amendment Letter

Submitted Date: 01/24/2013

Comments:

I attached a corrected version of the 165952 Executive Benefits Individual Application for Employer-Sponsored Guaranteed Issue Life Insurance to the Form Schedule tab. The previous version had the wrong form number in the lower left hand corner. No other changes were made to the application.

Thank you,
Wendy Paquin

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes								
Item No.	**Form Name**	**Form Number**	**Form Type**	**Form Action**	**Action Specific Data**	**Readability Score**	**Attachments**	**Submitted**
1	Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance	165952	AEF	Initial		52.100	165952_11302012_StateFiling.pdf	Date Submitted: 01/24/2013 By:
Previous Version								
1	*Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance*	*165952*	*AEF*	*Initial*		*52.100*	*165952_11302012_StateFiling.pdf*	*Date Submitted: 12/27/2012 By: Wendy Paquin*

No Rate Schedule Items Changed.

No Supporting Documents Changed.

State:	*Arkansas*	***Filing Company:***	*Security Life of Denver Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*165949 Apps*		
Project Name/Number:	*165949 Apps/165949 Apps*		

Note To Filer

Created By:

Linda Bird on 01/24/2013 10:02 AM

Last Edited By:

Linda Bird

Submitted On:

01/24/2013 10:02 AM

Subject:

Request to reopen

Comments:

Filing has been re-opened in order for correction to be made.

State:	*Arkansas*	***Filing Company:***	*Security Life of Denver Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*165949 Apps*		
Project Name/Number:	*165949 Apps/165949 Apps*		

Note To Reviewer

Created By:

Wendy Paquin on 01/24/2013 09:37 AM

Last Edited By:

Wendy Paquin

Submitted On:

01/24/2013 09:37 AM

Subject:

Request to Reopn

Comments:

Thank you for taking the time to discuss reopening this filing with me today.

We would like to reopen this filing because the 165952 Executive Benefits Individual Application for Employer-Sponsored Guaranteed Issue Life Insurance attached to the Form Schedule tab has the wrong form number in the lower left hand corner and we would like to attach the form with the correct form number. No other changes were made to the application.

Thank you,
Wendy Paquin

SERFF Tracking #:	*INGD-128729544*	***State Tracking #:***		***Company Tracking #:***	*165949 APPS*

State:	*Arkansas*	***Filing Company:***	*Security Life of Denver Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*165949 Apps*		
Project Name/Number:	*165949 Apps/165949 Apps*		

Form Schedule

Lead Form Number:

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1		Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance	165949	AEF	Initial		50.400	165949_11302012_StateFiling.pdf
2		Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance	165952	AEF	Initial		52.100	165952_11302012_StateFiling.pdf
3		Executive Benefits Application for Simplified Issue Life Insurance	165956	AEF	Initial		50.100	165956_11302012_StateFiling.pdf
4		Executive Benefits Temporary Insurance Receipt Guaranteed Issue	165967	AEF	Initial		53.000	165967_11302012_StateFiling.pdf
5		Executive Benefits Consent To Be Insured	165976	AEF	Initial		51.200	165976_11302012_StateFiling.pdf

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form

SERFF Tracking #:	*INGD-128729544*	***State Tracking #:***	***Company Tracking #:*** *165949 APPS*

State:	*Arkansas*	***Filing Company:***	*Security Life of Denver Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*165949 Apps*		
Project Name/Number:	*165949 Apps/165949 Apps*		

CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

EXECUTIVE BENEFITS MASTER APPLICATION FOR EMPLOYER-SPONSORED GUARANTEED ISSUE LIFE INSURANCE

Security Life of Denver Insurance Company
[8055 East Tufts Ave., Ste 650, Denver, CO 80237]
(the "Insurer")
[ING Customer Service Center: 2000 21st Ave. NW, Minot, ND 58703]

List Bill Number _____ **Plan Sponsor / Employer** _____

1. Is this insurance intended to be for a pension or similar tax-qualified plan? . . . . . ☐ Yes ☐ No
2. Will the policy be owned by a "Funded ERISA Plan"? . . . . . ☐ Yes ☐ No

If "Yes," please check one of the following:

☐ Tax qualified plan *(i.e., 401(k), profit sharing, defined benefit, defined contribution, HR10, 403(b))* _____

☐ Section 419/419A plan *(Specify trust name.)* _____

☐ VEBA Trust *(Specify trust name.)* _____

☐ Secular Trust

3. Is this subject to a split dollar endorsement? . . . . . ☐ Yes ☐ No

A. PROPOSED OWNER INFORMATION *(If the owner is a trust, provide a copy of the full Trust document or complete the Trust Certification.)*

1. Owner Name _____ 2. Owner SSN / TIN _____
3. Owner Address *(PO Boxes are not permitted.)* _____
   City _____ State _____ ZIP _____
4. Correspondence Address _____
   City _____ State _____ ZIP _____
5. Trustee Name *(If applicable.)* _____ 6. Date of Trust _____
7. Employer Name _____
8. Employer Address _____
   City _____ State _____ ZIP _____

B. BENEFICIARY INFORMATION

1. Beneficiary Name _____ 2. TIN _____

C. POLICY INFORMATION

1. Product Requested _____ 2. Policy Issue Date *(Month, Day, Year)* _____
3. Guaranteed Issue Version: ☐ Select or ☐ Regular 4. Rate: ☐ Unisex Version or ☐ Sex Distinct
5. Provide the formula used for calculating the Death Benefit Amount. _____

_____

_____

_____

6. Death Benefit Option: *(NOT ALL OPTIONS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)*
   If no option is selected, option will default to A.
   ☐ A or 1 (Level) ☐ B or 2 (Increasing or Variable)
   ☐ C or 3 (Face Amount + Premium) ☐ D or 4 (Face Amount + Premium + Interest % _____)
7. Death Benefit Qualification Test: *(If no option is selected, option will default to Guideline Premium Test.)*
   ☐ Guideline Premium Test ☐ Cash Value Accumulation Test

D. RIDER INFORMATION *(Check appropriate box and enter amounts. Automatic riders are not listed below. NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)*

☐ Adjustable Term Insurance Rider *(Specify rider amount.)* $ _____
(Specify total Death Benefit, including base & adjustable term rider.)
$ _____
☐ Early Cash Value Rider
☐ Guaranteed Death Benefit Rider *(An option below must be selected.)*
☐ Lifetime ☐ 20-Year ☐ To age 65 or 20 years, if later

☐ Guaranteed Minimum Accumulation Benefit Rider
☐ Waiver of Specified Premium Total Disability Rider
(Specify monthly premium - illustration required) $ _____
☐ Waiver of Surrender Charge Rider
☐ Other _____
☐ Other _____

E. BILLING INFORMATION

1. Send Premium Notices to: ☐ Employer ☐ Owner ☐ Other *(If "Other," provide name and address below.)*
2. Contact Name _____
3. Billing Address *(PO Boxes are not permitted.)* _____
   City _____ State _____ ZIP _____
4. Payment Method: ☐ List Bill ☐ Other _____
5. Payment Frequency: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly

F. IN FORCE / REPLACEMENT INFORMATION

1. Do you, as the Plan Sponsor / Employer, have life insurance or annuity contracts inforce or applied for? *(If "Yes," provide details below. Complete state required replacement form for model replacement regulation states ONLY.)* . . . . . ☐ Yes ☐ No
2. Are you, as the Plan Sponsor / Employer, considering using funds from existing policies or contracts to pay premiums due on the new policy or contract? *(If "Yes," complete state required replacement form and provide details below.)* . . . . . ☐ Yes ☐ No
3. Are you, as the Plan Sponsor / Employer, considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? *(If "Yes," complete state required replacement form and provide details below.)* . . . . . ☐ Yes ☐ No
4. Is this insurance intended to be a tax-free or 1035 exchange?. . . . . ☐ Yes ☐ No
   If "Yes," will a policy loan be carried over? . . . . . ☐ Yes ☐ No
5. For any "Yes" answer to questions 1-3, provide details regarding the policies in the chart below.

Owner Name	Insurance Company	Contract / Policy Number[1]	Account Value / Amount of Coverage[1]	Date Issued / Date Applied[1]
			$	
			$	
			$	

[1] *Include in attached census.*

G. AUTOMATIC TELEPHONE PRIVILEGES *(Complete for Variable Products ONLY)*

I understand that I may indicate below whether to allow telephone privileges to be provided to me and/or my agent / registered representative and his/her assistant. Telephone privileges allow an authorized person to call the Insurer to make certain elections and request certain transactions. The Insurer may use procedures to ensure instructions received by telephone are genuine, such as requiring forms of personal identification and tape recording phone calls. By accepting telephone privileges, I authorize the Insurer to record my telephone calls to the Insurer. The Insurer and its distributor will not be liable for any loss, damage, costs or expenses incurred in acting on telephone instructions reasonably believed to be genuine. I understand that if I do not want to authorize telephone privileges, I should not check either of the two boxes below. I also understand that once granted, such privileges will be revoked by upon receipt by the Insurer of signed, written instructions to terminate telephone privileges.

☐ I want telephone privileges.

☐ I want telephone privileges granted to my agent/registered representative and his/her assistant.

H. SUITABILITY / NEEDS ANALYSIS - VARIABLE PRODUCTS ONLY *(Completed by the Proposed Owner. Failing to provide this information will result in a delay in the issuing of new business.)*

1. Have you received a current prospectus including supplements for the variable life insurance policy? . . . . . ☐ Yes ☐ No

   Provide date of policy prospectus / supplement. _____

2. Do you understand that:
   a. The amount or duration of the policy death benefit may vary under specified conditions; **Policy values may increase or decrease with the investment experience of the variable investment options; Policy values may also increase with the interest credited in the Guaranteed Interest Division and/or the Indexed Credit Strategy, if applicable; The amount payable is not guaranteed, but is dependent on the account value and amounts owed under the policy?** . . . . . ☐ Yes ☐ No
   b. The fluctuation in values under the policy means that scheduled premium payments may not be sufficient to keep the policy in force in the event of market declines? . . . . . ☐ Yes ☐ No
   c. Personalized illustrations are based on hypothetical rates of return which may not be indicative of future investment experience of the variable investment options or of actual interest credited in the general account option(s)? . . . . . ☐ Yes ☐ No

I. POLICY BACKDATING INFORMATION

You may choose to backdate your policy up to six months (depending on state requirements). Backdating your policy may benefit you if you will become a year older within six months of the date your policy is issued. If you backdate your policy we will calculate the premium for your policy based on your "backdated" age. This could save you money in the future by allowing you to receive a lower premium. You would be required to pay the accumulated premium for the length of time that the policy is backdated. For instance, if you apply for a policy on August 1 and backdate the policy to June 1, you will be responsible for premium from June 1. This amount will be part of your initial premium payment only. Please consult your agent to determine the availability of backdating in your state and whether it is appropriate for your circumstances.

Would you like to backdate your policy? ☐ Yes *(If "Yes," review the policy backdating notice below.)*

POLICY BACKDATING NOTICE: As a policyholder, you have elected to backdate your policy, which enables you to gain benefits of lower age for the purposes of calculating cost of insurance charges on your policy.

If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment. You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

By my signature on the next page, I acknowledge that on backdated policies, the accrued cost of insurance charges deducted from the initial premium results in the values within the policy being lower than those illustrated. **I also understand that if I choose to pay premiums by automatic bank draft, my bank account will be drafted to "catch up" my policy premiums for each month that my policy is backdated.**

J. AGENT VERIFICATION *(For Agent Use ONLY)*

Agent Name / Broker-Dealer *(Please print.)*	Agent Number	% Split	General Agent Number	General Agent Name

K. SPECIAL INSTRUCTIONS

L. ACKNOWLEDGEMENTS, CERTIFICATIONS AND REPRESENTATIONS

Acknowledgements and Agreement: By signing this application, I acknowledge and agree that:

1. **Application:** I have read this application and I agree with the statements in this application.
2. **Rescission for False Statements:** The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully including without limitation, financial, employment and medical information.
3. **Information Limited to Application.** The application will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein.
4. **Company's Liability for Insurance Coverage.** Unless otherwise stated in a valid Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, there is no material change in the health of the Proposed Insured between the time of application and the time of delivery of the policy, and the first premium is received by the Company while the Proposed Insured is alive.
5. **Temporary Insurance.** If I have paid premium by check with this application, I have completed the Temporary Insurance Receipt.
6. **No Waiver by Producer.** The producer does not have the authority to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements.

L. ACKNOWLEDGEMENTS, CERTIFICATIONS AND REPRESENTATIONS *(Continued)*

7. **Application Changes.** No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing.
8. **Delivery Requirements.** If a policy is underwritten and issued as a result of this application, all required documents pertaining to the delivery of the policy must be completed and returned to the issuing company within 60 days of receipt. Otherwise, the policy will not be in force.
9. **Signature.** By signing this application, I am applying for life insurance coverage issued by the Company.
10. **Receipt of Disclosure and Forms.** I received the following disclosures and notices: Accelerated Benefit Rider Disclosure, Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices.
11. **Governing Law.** The Policy shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.
12. **Jurisdiction.** Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Policy or sale of the Policy ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Policy is delivered. The state and federal courts located in the state in which the Policy is delivered shall have jurisdiction over the parties to the Action or Proceeding.

Certification. By signing this application, I certify, under penalty of perjury, that my Social Security Number / Tax Identification Number is shown and is correct and that I am not subject to back-up withholding.

Representations. By signing this application, I represent that:

1. All questions have been truthfully answered to the best of my knowledge and belief.
2. The policy is not STOLI and I have not engaged in any prohibited conduct as described in Appendix A.
3. The Owner has an insurable interest in the life of the Proposed Insured.
4. I agree to inform the Company of any known material change in health of the Proposed Insured prior to delivery of the Policy.

Census Information

☐ A census containing all required participant information has been provided with this application for life insurance.

False or Misleading Information – Criminal and Civil Penalties / Denial of Insurance Benefits: I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

In what city and state did the **Proposed Owner** sign this application? *(City)* _____ *(State)* _____

Proposed Owner/Trustee Signature _____ Date _____

Owner/Trustee Name *(Please print.)* _____

Owner Title *(If applicable.) (Please print.)* _____

I agree to be bound by the terms and conditions of the current [ING Life Companies] General Agent or Producer Agreement ("Agreement"), unless I am an employee / registered representative of a Broker-Dealer and do not hold an Agreement such that this language is inapplicable. I understand that I may receive an additional copy of my agent agreement and/or current compensation schedule from the Insurer by contacting Distributor Services at 877-882-5050.

I certify that all sales materials used during this sale were approved by the Insurer. Copies of all sales materials were left with the applicant no later than the time of application. (Electronically presented sales materials will be provided to the policy owner no later than at the time of the policy delivery.) All replacement sales were made in accordance with the Insurer's corporate policy. I acknowledge that I have delivered the Important Notices to the Proposed Insured(s) or Proposed Owner.

I represent that the policy applied for is not STOLI as described in Appendix A, "[ING's Policy on Stranger-Owned or Stranger-Originated Life Insurance (STOLI).]" I represent that I am not aware that the applicant is applying for insurance coverage for a stranger as part of a STOLI arrangement and neither I nor the applicant are aware of any information that would notify the Company of the policy's use as STOLI. Neither I nor the applicant have provided any information to the Company contrary to the representations I have made and the applicant has made concerning the policy's use as STOLI. My signature also certifies that except as provided in the answers to the in force replacement questions, the proposed insured(s) / owner(s) do not own any existing life insurance or annuity contracts and no other replacement of insurance or annuity is involved in this transaction. I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

To the best of my knowledge and belief, all answers provided by the Owner and Proposed Insured in the above application are true, correct and complete.

Writing Agent / Registered Rep. Signature _____ Date _____

Writing Agent/Registered Rep. Name *(Please print.)* _____

Phone (_____) _____ E-mail Address _____

Address _____ City _____ State _____ ZIP _____

SPLIT SALES ONLY

Agent Name _____ Agent Name _____

PLEASE PROVIDE THE OWNER WITH A COPY OF THIS APPLICATION.

EXECUTIVE BENEFITS INDIVIDUAL APPLICATION FOR EMPLOYER-SPONSORED GUARANTEED ISSUE LIFE INSURANCE

Security Life of Denver Insurance Company
[8055 East Tufts Ave., Ste 650, Denver, CO 80237]
(the "Insurer")
[ING Customer Service Center: 2000 21st Ave. NW, Minot, ND 58703]

List Bill Number _____ **Plan Sponsor / Employer** _____

1. Is this insurance intended to be for a pension or similar tax-qualified plan? . . . . . ☐ Yes ☐ No
2. Will the policy be owned by a "Funded ERISA Plan"? . . . . . ☐ Yes ☐ No

If "Yes," please check one of the following:

☐ Tax qualified plan *(i.e., 401(k), profit sharing, defined benefit, defined contribution, HR10, 403(b))* _____
☐ Section 419/419A plan *(Specify trust name.)* _____
☐ VEBA Trust *(Specify trust name.)* _____
☐ Secular Trust

3. Is this subject to a split dollar collateral assignment? . . . . . ☐ Yes ☐ No

A. PROPOSED INSURED INFORMATION

1. First Name _____ MI _____ Last Name _____

2. Gender: ☐ Male ☐ Female 3. Birth Date _____ 4. SSN or Government Issued ID Number _____

5. Address *(PO Boxes are not permitted.)* _____

City _____ State _____ ZIP _____

6. Home Phone (_____) _____ 7. Work Phone (_____) _____

8. Driver's License Number _____ 9. Driver's License State _____
(If you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)

10. Name on Driver's License *(If different than above.)* _____

11. Employer Name _____ 12. Annual Salary $_____ 13. Annual Bonus $_____

14. Employer Address _____

15. Title _____ 16. Date of Hire _____

17. Are you a U.S. citizen? . . . . . ☐ Yes ☐ No
If "No," please explain and provide country of citizenship and status. _____

18. During the 90 days prior to the date this application is signed, have you (1) been employed or been a Director or Partner of the Plan Sponsor / Employer continuously **AND** are you (2) actively performing normal duties at your customary place of employment for at least 30 hours per week? . . . . . ☐ Yes ☐ No
If "No," please explain. _____

19. During the 90 days prior to the date this application is signed, have you (1) been absent from work due to illness, accident or medical treatment for either more than 3 consecutive days or a total of 5 days or more (not including vacations or holidays) **OR** (2) sought or received care or treatment (outpatient or inpatient) at any type of hospital, emergency room, or urgent care facility? . . . . . ☐ Yes ☐ No
If "Yes," provide medical details. _____

20. Have you used any tobacco or nicotine products within the last 12 months? *(e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches)* . . . . . ☐ Yes ☐ No

If "Yes," indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____

B. PROPOSED OWNER INFORMATION *(Complete if other than Proposed Insured. If the owner is a trust, provide a copy of the full Trust document or complete the Trust Certification.)*

1. Owner Name _____ 2. Owner SSN/TIN _____

3. Owner Address *(PO Boxes are not permitted.)* _____

City _____ State _____ ZIP _____

4. Correspondence Address _____

City _____ State _____ ZIP _____

5. Relationship to Proposed Insured: ☐ Trust ☐ Other _____

6. Trustee Name *(If applicable.)* _____ 7. Date of Trust _____

C. BENEFICIARY INFORMATION *(Total percentage of primary beneficiaries shares must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Please use whole percents. If no percentages are listed, beneficiaries' shares will be distributed equally; however, partial percentages are not allowed so the first listed beneficiary will receive the largest whole percentage.)*

Individual as a Beneficiary *(Complete the table below.)*

Name *(First, MI, Last)*	Birth Date	Gender	SSN	Relationship	%	Beneficiary Type
		☐ Male ☐ Female				☐ Primary ☐ Contingent
		☐ Male ☐ Female				☐ Primary ☐ Contingent
		☐ Male ☐ Female				☐ Primary ☐ Contingent
		☐ Male ☐ Female				☐ Primary ☐ Contingent

Trust or Business / Corporation as a Beneficiary *(Complete the table below.)*

Trust or Business / Corporation Name	Trust Date	State of Incorporation / Domicile	%	Beneficiary Type
				☐ Primary ☐ Contingent
				☐ Primary ☐ Contingent

D. POLICY INFORMATION

1. Product Requested _____ 2. Policy Issue Date *(Month, Day, Year)* _____

3. Base Coverage $_____ *(Not including Riders - See Section E for Adjustable Term Insurance Rider.)*

4. Guaranteed Issue Version: ☐ Select or ☐ Regular 5. Rate: ☐ Unisex Version or ☐ Sex Distinct

6. Death Benefit Option: *(NOT ALL OPTIONS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)*

If no option is selected, option will default to A.

☐ A or 1 (Level) ☐ B or 2 (Increasing or Variable)

☐ C or 3 (Face Amount + Premium) ☐ D or 4 (Face Amount + Premium + Interest % _____)

7. Death Benefit Qualification Test: *(If no option is selected, option will default to Guideline Premium Test.)*

☐ Guideline Premium Test ☐ Cash Value Accumulation Test

E. RIDER INFORMATION *(Check appropriate box and enter amounts. Automatic riders are not listed below. NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)*

☐ Adjustable Term Insurance Rider *(Specify rider amount.)* $ _____

(Specify total Death Benefit, including base & adjustable term rider.)

$ _____

☐ Early Cash Value Rider

☐ Guaranteed Death Benefit Rider *(An option below must be selected.)*

☐ Lifetime ☐ 20-Year ☐ To age 65 or 20 years, if later

☐ Guaranteed Minimum Accumulation Benefit Rider

☐ Waiver of Specified Premium Total Disability Rider

(Specify monthly premium - illustration required) $ _____

☐ Waiver of Surrender Charge Rider

☐ Other _____

☐ Other _____

F. BILLING INFORMATION

1. Send Premium Notices to: ☐ Employer ☐ Owner ☐ Other *(If "Other," provide name and address below.)*

2. Contact Name _____

3. Billing Address *(PO Boxes are not permitted.)* _____

City _____ State _____ ZIP _____

4. Payment Method: ☐ List Bill ☐ Other _____

5. Payment Frequency: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly

G. IN FORCE / REPLACEMENT INFORMATION

1. Do you currently have life insurance or annuity contracts inforce or applied for? *(If "Yes," provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.)* . . . . ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? *(If "Yes," complete state required replacement form and provide details below.)* . . . . ☐ Yes ☐ No
3. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? *(If "Yes," complete state required replacement form and provide details below.)* . . . . ☐ Yes ☐ No
4. Is this insurance intended to be a tax-free or 1035 exchange?. . . . . ☐ Yes ☐ No
   If "Yes," will a policy loan be carried over? . . . . . ☐ Yes ☐ No

5. For any "Yes" answer to questions 1-3, provide details regarding the policies in the chart below.

Owner Name	Insurance Company	Contract / Policy Number[1]	Account Value / Amount of Coverage[1]	Date Issued / Date Applied[1]
			$	
			$	
			$	

[1] *Include in attached census.*

H. AUTOMATIC TELEPHONE PRIVILEGES *(Complete for Variable Products ONLY)*

I understand that I may indicate below whether to allow telephone privileges to be provided to me and/or my agent / registered representative and his/her assistant. Telephone privileges allow an authorized person to call the Insurer to make certain elections and request certain transactions. The Insurer may use procedures to ensure instructions received by telephone are genuine, such as requiring forms of personal identification and tape recording phone calls. By accepting telephone privileges, I authorize the Insurer to record my telephone calls to the Insurer. The Insurer and its distributor will not be liable for any loss, damage, costs or expenses incurred in acting on telephone instructions reasonably believed to be genuine. I understand that if I do not want to authorize telephone privileges, I should not check either of the two boxes below. I also understand that once granted, such privileges will be revoked by upon receipt by the Insurer of signed, written instructions to terminate telephone privileges.

☐ I want telephone privileges.

☐ I want telephone privileges granted to my agent/registered representative and his/her assistant.

I. SUITABILITY / NEEDS ANALYSIS - VARIABLE PRODUCTS ONLY *(Completed by the Proposed Owner. Failing to provide this information will result in a delay in the issuing of new business.)*

1. Have you received a current prospectus including supplements for the variable life insurance policy? . . . . . ☐ Yes ☐ No

   Provide date of policy prospectus / supplement. _____

2. Do you understand that:
   a. The amount or duration of the policy death benefit may vary under specified conditions; **Policy values may increase or decrease with the investment experience of the variable investment options; Policy values may also increase with the interest credited in the Guaranteed Interest Division and/or the Indexed Credit Strategy, if applicable; The amount payable is not guaranteed, but is dependent on the account value and amounts owed under the policy?** . . . . . ☐ Yes ☐ No
   b. The fluctuation in values under the policy means that scheduled premium payments may not be sufficient to keep the policy in force in the event of market declines? . . . . . ☐ Yes ☐ No
   c. Personalized illustrations are based on hypothetical rates of return which may not be indicative of future investment experience of the variable investment options or of actual interest credited in the general account option(s)? . . . . . ☐ Yes ☐ No

J. POLICY BACKDATING INFORMATION

You may choose to backdate your policy up to six months (depending on state requirements). Backdating your policy may benefit you if you will become a year older within six months of the date your policy is issued. If you backdate your policy we will calculate the premium for your policy based on your "backdated" age. This could save you money in the future by allowing you to receive a lower premium. You would be required to pay the accumulated premium for the length of time that the policy is backdated. For instance, if you apply for a policy on August 1 and backdate the policy to June 1, you will be responsible for premium from June 1. This amount will be part of your initial premium payment only. Please consult your agent to determine the availability of backdating in your state and whether it is appropriate for your circumstances.

Would you like to backdate your policy? ☐ Yes *(If "Yes," review the policy backdating notice below.)*

POLICY BACKDATING NOTICE: As a policyholder, you have elected to backdate your policy, which enables you to gain benefits of lower age for the purposes of calculating cost of insurance charges on your policy.

If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment. You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

By my signature on the next page, I acknowledge that on backdated policies, the accrued cost of insurance charges deducted from the initial premium results in the values within the policy being lower than those illustrated. **I also understand that if I choose to pay premiums by automatic bank draft, my bank account will be drafted to "catch up" my policy premiums for each month that my policy is backdated.**

K. AGENT VERIFICATION *(For Agent Use ONLY)*

Agent Name / Broker-Dealer *(Please print.)*	Agent Number	% Split	General Agent Number	General Agent Name

L. SPECIAL INSTRUCTIONS

M. ACKNOWLEDGEMENTS, CERTIFICATIONS AND REPRESENTATIONS

Acknowledgements and Agreement: By signing this application, I acknowledge and agree that:

1. **Application:** I have read this application and I agree with the statements in this application.
2. **Rescission for False Statements:** The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully including without limitation, financial, employment and medical information.
3. **Information Limited to Application.** The application will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein.
4. **Company's Liability for Insurance Coverage.** Unless otherwise stated in a valid Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, there is no material change in the health of the Proposed Insured between the time of application and the time of delivery of the policy, and the first premium is received by the Company while the Proposed Insured is alive.
5. **Temporary Insurance.** If I have paid premium by check with this application, I have completed the Temporary Insurance Receipt.
6. **No Waiver by Producer.** The producer does not have the authority to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements.

M. ACKNOWLEDGEMENTS, CERTIFICATIONS AND REPRESENTATIONS *(Continued)*

7. **Application Changes.** No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing.
8. **Delivery Requirements.** If a policy is underwritten and issued as a result of this application, all required documents pertaining to the delivery of the policy must be completed and returned to the issuing company within 60 days of receipt. Otherwise, the policy will not be in force.
9. **Signature.** By signing this application, I am applying for life insurance coverage issued by the Company.
10. **Receipt of Disclosure and Forms.** I received the following disclosures and notices: Accelerated Benefit Rider Disclosure, Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices.
11. **Governing Law.** The Policy shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.
12. **Jurisdiction.** Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Policy or sale of the Policy ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Policy is delivered. The state and federal courts located in the state in which the Policy is delivered shall have jurisdiction over the parties to the Action or Proceeding.

Certification. By signing this application, I certify, under penalty of perjury, that my Social Security Number/ Tax Identification Number is shown and is correct and that I am not subject to back-up withholding.

Representations. By signing this application, I represent that:

1. All questions have been truthfully answered to the best of my knowledge and belief.
2. The policy is not STOLI and I have not engaged in any prohibited conduct as described in Appendix A.
3. The Owner has an insurable interest in the life of the Proposed Insured.
4. I agree to inform the Company of any known material change in health of the Proposed Insured prior to delivery of the Policy.

Acknowledgement of Insured

As proposed insured of this policy:

☐ I acknowledge that no illustration was provided to me in connection with this application either before or at the time the application was signed.

☐ I acknowledge that an illustration was provided to me in connection with this application either before or at the time the application was signed.

I authorize the Employer listed in this application to accept delivery of the policy, to sign any illustration, and to apply for future changes on my behalf.

False or Misleading Information – Criminal and Civil Penalties / Denial of Insurance Benefits: I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

In what city and state did the **Proposed Owner** sign this application? *(City)* _____ *(State)* _____

Proposed Insured Signature _____ Date _____

Proposed Owner/Trustee Signature _____ Date _____

Owner / Trustee Name *(Please print.)* _____

Owner Title *(If applicable.) (Please print.)* _____

I agree to be bound by the terms and conditions of the current [ING Life Companies] General Agent or Producer Agreement ("Agreement"), unless I am an employee / registered representative of a Broker-Dealer and do not hold an Agreement such that this language is inapplicable. I understand that I may receive an additional copy of my agent agreement and/or current compensation schedule from the Insurer by contacting Distributor Services at 877-882-5050.

I certify that all sales materials used during this sale were approved by the Insurer. Copies of all sales materials were left with the applicant no later than the time of application. (Electronically presented sales materials will be provided to the policy owner no later than at the time of the policy delivery.) All replacement sales were made in accordance with the Insurer's corporate policy. I acknowledge that I have delivered the Important Notices to the Proposed Insured(s) or Proposed Owner.

I represent that the policy applied for is not STOLI as described in Appendix A, "[ING's Policy on Stranger-Owned or Stranger-Originated Life Insurance (STOLI).]" I represent that I am not aware that the applicant is applying for insurance coverage for a stranger as part of a STOLI arrangement and neither I nor the applicant are aware of any information that would notify the Company of the policy's use as STOLI. Neither I nor the applicant have provided any information to the Company contrary to the representations I have made and the applicant has made concerning the policy's use as STOLI. My signature also certifies that except as provided in the answers to the in force replacement questions, the proposed insured(s) / owner(s) do not own any existing life insurance or annuity contracts and no other replacement of insurance or annuity is involved in this transaction. I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

To the best of my knowledge and belief, all answers provided by the Owner and Proposed Insured in the above application are true, correct and complete.

Writing Agent / Registered Rep. Signature _____ Date _____

Writing Agent / Registered Rep. Name *(Please print.)* _____

Phone (_____) _____ E-mail Address _____

Address _____ City _____ State _____ ZIP _____

SPLIT SALES ONLY

Agent Name _____ Agent Name _____

PLEASE PROVIDE THE PROPOSED OWNER / PROPOSED INSURED WITH A COPY OF THIS APPLICATION.

EXECUTIVE BENEFITS APPLICATION FOR SIMPLIFIED ISSUE LIFE INSURANCE

Security Life of Denver Insurance Company
[8055 East Tufts Ave., Ste 650, Denver, CO 80237]
(the "Insurer")
[ING Customer Service Center: 2000 21st Ave. NW, Minot, ND 58703]

List Bill Number _____ **Plan Sponsor / Employer** _____

1. Is this insurance intended to be for a pension or similar tax-qualified plan? . . . . . ☐ Yes ☐ No
2. Will the policy be owned by a "Funded ERISA Plan"? . . . . . ☐ Yes ☐ No

If "Yes," please check one of the following:

☐ Tax qualified plan *(i.e., 401(k), profit sharing, defined benefit, defined contribution, HR10, 403(b))* _____
☐ Section 419/419A plan *(Specify trust name.)* _____
☐ VEBA Trust *(Specify trust name.)* _____
☐ Secular Trust

3. Is this subject to a split dollar? ☐ Yes ☐ No *If "yes," indicate the type of split dollar.* ☐ Collateral Assignment ☐ Endorsement

A. PROPOSED INSURED INFORMATION

1. First Name _____ MI _____ Last Name _____
2. Gender: ☐ Male ☐ Female 3. Birth Date _____ 4. SSN or Government Issued ID Number _____
5. Address *(PO Boxes are not permitted.)* _____
   City _____ State _____ ZIP _____
6. Home Phone (_____)_____ 7. Work Phone (_____)_____
8. Driver's License Number _____ 9. Driver's License State _____
   (If you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)
10. Name on Driver's License *(if different than above)* _____
11. Employer Name _____ 12. Annual Salary $_____ 13. Annual Bonus $_____
14. Employer Address _____
    City _____ State _____ ZIP _____
15. Title _____ 16. Date of Hire _____
17. Are you a U.S. citizen? . . . . . ☐ Yes ☐ No
    If "No," please explain and provide country of citizenship and status. _____
18. During the 90 days prior to the date this application is signed, have you (1) been employed or been a Director or Partner of the Plan Sponsor / Employer continuously **AND** are you (2) actively performing normal duties at your customary place of employment for at least 30 hours per week? . . . . . ☐ Yes ☐ No
    If "No," please explain. _____
19. During the 90 days prior to the date this application is signed, have you (1) been absent from work due to illness, accident or medical treatment for either more than 3 consecutive days or a total of 5 days or more (not including vacations or holidays) **OR** (2) sought or received care or treatment (outpatient or inpatient) at any type of hospital, emergency room, or urgent care facility? . . . . . ☐ Yes ☐ No
    If "Yes," provide medical details. _____
20. Have you used any tobacco or nicotine products within the last 12 months? *(e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches)* . . . . . ☐ Yes ☐ No
    If "Yes," indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____

B. PROPOSED OWNER INFORMATION *(Complete if other than Proposed Insured. If the owner is a trust, provide a copy of the full Trust document or complete the Trust Certification.)*

1. Owner Name _____ 2. Owner SSN / TIN _____

3. Owner Address *(PO Boxes are not permitted.)* _____

City _____ State _____ ZIP _____

4. Correspondence Address _____

City _____ State _____ ZIP _____

5. Relationship to Proposed Insured: ☐ Trust ☐ Other _____

6. Trustee Name *(If applicable.)* _____ 7. Date of Trust _____

C. BENEFICIARY INFORMATION *(Total percentage of primary beneficiaries shares must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Please use whole percents. If no percentages are listed, beneficiaries' shares will be distributed equally; however, partial percentages are not allowed so the first listed beneficiary will receive the largest whole percentage.)*

Individual as a Beneficiary *(Complete the table below.)*

Name *(First, MI, Last)*	Birth Date	Gender	SSN	Relationship	%	Beneficiary Type
		☐ Male ☐ Female				☐ Primary ☐ Contingent
		☐ Male ☐ Female				☐ Primary ☐ Contingent
		☐ Male ☐ Female				☐ Primary ☐ Contingent
		☐ Male ☐ Female				☐ Primary ☐ Contingent

Trust or Business / Corporation as a Beneficiary *(Complete the table below.)*

Trust or Business / Corporation Name	Trust Date	State of Incorporation / Domicile	%	Beneficiary Type
				☐ Primary ☐ Contingent
				☐ Primary ☐ Contingent

D. POLICY INFORMATION

1. Product Requested _____ 2. Policy Issue Date *(Month, Day, Year)* _____

3. Guaranteed Issue Version: ☐ Select or ☐ Regular 4. Rate: ☐ Unisex Version or ☐ Sex Distinct

5. Base Coverage $_____ *(Not including Riders - See Section E for Adjustable Term Insurance Rider.)*

6. Death Benefit Option: *(If no option is selected, option will default to A.)*

☐ A or 1 - Level ☐ B or 2 - Increasing or Variable

☐ C or 3 - Face Amount + Premium ☐ D or 4 - Face Amount + Premium + Interest _____ %

7. Death Benefit Qualification Test: *(If no option is selected, option will default to Guideline Premium Test.)*

☐ Guideline Premium Test ☐ Cash Value Accumulation Test

E. RIDER INFORMATION *(Check appropriate box and enter amounts. Automatic riders are not listed below. NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)*

☐ Adjustable Term Insurance Rider *(Specify Rider amount)* $ _____
(Specify total Death Benefit, including base & adjustable term rider.)
$ _____

☐ Early Cash Value Rider

☐ Guaranteed Death Benefit Rider *(An option below must be selected.)*
☐ Lifetime ☐ 20-Year ☐ To age 65 or 20 years, if later

☐ Guaranteed Minimum Accumulation Benefit Rider

☐ Waiver of Specified Premium Total Disability Rider
(Specify monthly premium - illustration required) $ _____

☐ Waiver of Surrender Charge Rider

☐ Other _____

☐ Other _____

F. BILLING INFORMATION

1. Send Premium Notices to: ☐ Employer ☐ Owner ☐ Other *(If "Other," provide name and address below.)*

2. Contact Name _____

3. Billing Address *(PO Boxes are not permitted.)* _____

City _____ State _____ ZIP _____

4. Payment Method: ☐ List Bill ☐ Other _____ 5. Payment Frequency: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly

G. IN FORCE / REPLACEMENT INFORMATION

1. Do you currently have life insurance or annuity contracts inforce or applied for? *(If "Yes," provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.)* . . . ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? *(If "Yes," complete state required replacement form and provide details below.)* . . . ☐ Yes ☐ No
3. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? *(If "Yes," complete state required replacement form and provide details below.)* . . . ☐ Yes ☐ No
4. Is this insurance intended to be a tax-free or 1035 exchange? . . . ☐ Yes ☐ No
   If "Yes," will a policy loan be carried over? . . . ☐ Yes ☐ No

5. For any "Yes" answer to questions 1-3, provide details regarding the policies in the chart below.

Owner Name	Insurance Company	Contract / Policy Number[1]	Account Value / Amount of Coverage[1]	Date Issued / Date Applied[1]
			$	
			$	
			$	

[1] *Include in attached census.*

H. PROPOSED INSURED PERSONAL AND MEDICAL HISTORY

1. Has the Proposed Insured ever had life or health insurance (or reinstatement) postponed, limited, rated, canceled, refused or declined? *(If "Yes," provide details on the next page.)* . . . ☐ Yes ☐ No
2. Has the Proposed Insured ever declared bankruptcy? *(If "Yes," provide details in following chart, including date discharged.)* . . . ☐ Yes ☐ No
3. Does the Proposed Insured intend to travel or reside outside the United States or Canada in the next two years? *(If "Yes," complete the Foreign Travel and Residence Questionnaire.)* . . . ☐ Yes ☐ No
4. Does the Proposed Insured anticipate flying a plane (other than as a commercial pilot), racing motor boats, automobiles or motorcycles, or participating in sky-diving, hang-gliding or other hazardous activities? *(If "Yes," complete the appropriate hazardous activities questionnaire.)* . . . ☐ Yes ☐ No
5. Has the Proposed Insured, in the last five years, had any motor vehicle accidents, alcohol or drug related convictions, or other moving violations while operating a motor vehicle? . . . ☐ Yes ☐ No
6. In the past 10 years, has the Proposed Insured ever been treated for or been diagnosed by a member of the medical profession or a health practitioner as having heart trouble, emphysema, a stroke, high blood pressure, chest pain, diabetes, kidney or liver disease, nervous disorder, chronic respiratory disorder, a tumor, or cancer? . . . ☐ Yes ☐ No
7. In the past five years, has the Proposed Insured been treated for or diagnosed as having any other disease, illness or impairment not mentioned above? . . . ☐ Yes ☐ No
8. In the past 10 years, has the Proposed Insured ever been treated for or been diagnosed by a member of the medical profession or a health practitioner as having a positive HIV test, AIDS (Acquired Immunodeficiency Syndrome), or other disease or disorder of the immune system? . . . ☐ Yes ☐ No
9. Has the Proposed Insured sought or been advised to seek advice or treatment for the use of alcohol? *(If "Yes," complete Alcohol Usage Questionnaire.)* . . . ☐ Yes ☐ No
10. In the past 10 years, has the Proposed Insured been confined for observation, care, or treatment in a hospital or other health care facility? . . . ☐ Yes ☐ No
11. In the past five years, has the Proposed Insured consulted any health care provider(s) not already identified, for any reason, including routine physical examinations? . . . ☐ Yes ☐ No
12. Is the Proposed Insured presently taking any medication(s), including non-prescription/over-the-counter medication or supplements? ☐ Yes ☐ No
13. Is the Proposed Insured currently using or have you ever used Ecstasy, marijuana, cocaine, amphetamines, barbiturates, hallucinogenic agents, narcotics, or any other drug except as legally prescribed by a health care provider? *(If "Yes", complete Drug Use Questionnaire.)* . . . ☐ Yes ☐ No

I. PROPOSED INSURED PERSONAL AND MEDICAL HISTORY *(Continued)*

For any "Yes" answer to questions 1, 2, 5, 6, 7, 8, 10, 11 or 12, please record information in the chart below.

Ques. #	Explanation

14. Proposed Insured's Height _____ 15. Proposed Insured's Weight _____ 16. Loss or gain in pounds during the last year _____

17. Insured's Personal Physician Name _____ 18. Phone (_____)_____

19. Physician Address _____

City _____ State _____ ZIP _____

20. Date Last Consulted and Reason _____

J. AUTOMATIC TELEPHONE PRIVILEGES *(Complete for Variable Products ONLY)*

I understand that I may indicate below whether to allow telephone privileges to be provided to me and/or my agent / registered representative and his/her assistant. Telephone privileges allow an authorized person to call the Insurer to make certain elections and request certain transactions. The Insurer may use procedures to ensure instructions received by telephone are genuine, such as requiring forms of personal identification and tape recording phone calls. By accepting telephone privileges, I authorize the Insurer to record my telephone calls to the Insurer. The Insurer and its distributor will not be liable for any loss, damage, costs or expenses incurred in acting on telephone instructions reasonably believed to be genuine. I understand that if I do not want to authorize telephone privileges, I should not check either of the two boxes below. I also understand that once granted, such privileges will be revoked by upon receipt by the Insurer of signed, written instructions to terminate telephone privileges.

☐ I want telephone privileges.

☐ I want telephone privileges granted to my agent/registered representative and his/her assistant.

K. SUITABILITY / NEEDS ANALYSIS - VARIABLE PRODUCTS ONLY *(Completed by the Proposed Owner. Failing to provide this information will result in a delay in the issuing of new business.)*

1. Have you received a current prospectus including supplements for the variable life insurance policy? . . . . . ☐ Yes ☐ No

Provide date of policy prospectus / supplement. _____

2. Do you understand that:
   a. The amount or duration of the policy death benefit may vary under specified conditions; **Policy values may increase or decrease with the investment experience of the variable investment options; Policy values may also increase with the interest credited in the Guaranteed Interest Division and/or the Indexed Credit Strategy, if applicable; The amount payable is not guaranteed, but is dependent on the account value and amounts owed under the policy?** . . . . . ☐ Yes ☐ No
   b. The fluctuation in values under the policy means that scheduled premium payments may not be sufficient to keep the policy in force in the event of market declines? . . . . . ☐ Yes ☐ No
   c. Personalized illustrations are based on hypothetical rates of return which may not be indicative of future investment experience of the variable investment options or of actual interest credited in the general account option(s)? . . . . . ☐ Yes ☐ No

L. POLICY BACKDATING INFORMATION

You may choose to backdate your policy up to six months (depending on state requirements). Backdating your policy may benefit you if you will become a year older within six months of the date your policy is issued. If you backdate your policy we will calculate the premium for your policy based on your "backdated" age. This could save you money in the future by allowing you to receive a lower premium. You would be required to pay the accumulated premium for the length of time that the policy is backdated. For instance, if you apply for a policy on August 1 and backdate the policy to June 1, you will be responsible for premium from June 1. This amount will be part of your initial premium payment only. Please consult your agent to determine the availability of backdating in your state and whether it is appropriate for your circumstances.

Would you like to backdate your policy? ☐ Yes *(If "Yes," review the policy backdating notice on the next page.)*

L. POLICY BACKDATING INFORMATION *(Continued)*

POLICY BACKDATING NOTICE: As a policyholder, you have elected to backdate your policy, which enables you to gain benefits of lower age for the purposes of calculating cost of insurance charges on your policy.

If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment. You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

By my signature on the next page, I acknowledge that on backdated policies, the accrued cost of insurance charges deducted from the initial premium results in the values within the policy being lower than those illustrated. **I also understand that if I choose to pay premiums by automatic bank draft, my bank account will be drafted to "catch up" my policy premiums for each month that my policy is backdated.**

M. CONSENT TO BE INSURED *(For corporate-owned and trust-owned policies only.)*

If I consent to be insured, I acknowledge, understand and agree to the following:

- An Insurer, selected by the Plan Sponsor / Employer, will issue to the Plan Sponsor/Employer a life insurance policy on my life.
- The Plan Sponsor / Employer may purchase the insurance directly or through a trust established by the Plan Sponsor / Employer.
- The Plan Sponsor / Employer or trust has an insurable interest in my life.
- The Plan Sponsor / Employer or trust will apply for, own and control the insurance policy in every respect.
- Neither I nor my estate, administrators, heirs or assignees have any rights in the policy or in any policy proceeds, unless the Plan Sponsor / Employer otherwise notifies the Insurer in writing.
- The Plan Sponsor / Employer or trust, or its successors, will continue to be the owner and beneficiary of the life insurance policy indefinitely, including after my employment with, or status as director of, the Plan Sponsor / Employer terminates, whenever and for whatever reason this may occur.

☐ Yes I, the undersigned, have read and understand this Consent to Be Insured, agree that the information contained herein is accurate and complete to the best of my knowledge and belief, and willingly choose to consent as indicated above. I also agree that the Insurer may rely upon the statements and answers in this form in determining the pricing and the issuance of any insurance policies issued on my life, and that the form may be attached to and made part of any such insurance policy.

☐ No I do not consent to have insurance purchased on my life.

N. AGENT VERIFICATION *(For Agent Use ONLY)*

Agent Name / Broker-Dealer *(Please print.)*	Agent Number	% Split	General Agent Number	General Agent Name

O. SPECIAL INSTRUCTIONS

P. ACKNOWLEDGEMENTS, CERTIFICATIONS AND REPRESENTATIONS

Acknowledgements and Agreement: By signing this application, I acknowledge and agree that:

1. **Application:** I have read this application and I agree with the statements in this application.
2. **Rescission for False Statements:** The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully including without limitation, financial, employment and medical information.
3. **Information Limited to Application.** The application will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein.
4. **Company's Liability for Insurance Coverage.** Unless otherwise stated in a valid Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, there is no material change in the health of the Proposed Insured between the time of application and the time of delivery of the policy, and the first premium is received by the Company while the Proposed Insured is alive.
5. **Temporary Insurance.** If I have paid premium by check with this application, I have completed the Temporary Insurance Receipt.
6. **No Waiver by Producer.** The producer does not have the authority to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements.
7. **Application Changes.** No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing.
8. **Delivery Requirements.** If a policy is underwritten and issued as a result of this application, all required documents pertaining to the delivery of the policy must be completed and returned to the issuing company within 60 days of receipt. Otherwise, the policy will not be in force.
9. **Signature.** By signing this application, I am applying for life insurance coverage issued by the Company.
10. **Receipt of Disclosure and Forms.** I received the following disclosures and notices: Accelerated Benefit Rider Disclosure, Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices.

P. ACKNOWLEDGEMENTS, CERTIFICATIONS AND REPRESENTATIONS *(Continued)*

11. **Governing Law.** The Policy shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.
12. **Jurisdiction.** Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Policy or sale of the Policy ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Policy is delivered. The state and federal courts located in the state in which the Policy is delivered shall have jurisdiction over the parties to the Action or Proceeding.

Certification. By signing this application, I certify, under penalty of perjury, that my Social Security Number/ Tax Identification Number is shown and is correct and that I am not subject to back-up withholding.

Representations. By signing this application, I represent that:

1. All questions have been truthfully answered to the best of my knowledge and belief.
2. The policy is not STOLI and I have not engaged in any prohibited conduct as described in Appendix C.
3. The Owner has an insurable interest in the life of the Proposed Insured.
4. I agree to inform the Company of any known material change in health of the Proposed Insured prior to delivery of the Policy.

Acknowledgement of Insured

As proposed insured of this policy:

☐ I acknowledge that no illustration was provided to me in connection with this application either before or at the time the application was signed.

☐ I acknowledge that an illustration was provided to me in connection with this application either before or at the time the application was signed.

I authorize the Employer listed in this application to accept delivery of the policy, to sign any illustration, and to apply for future changes on my behalf.

False or Misleading Information – Criminal and Civil Penalties / Denial of Insurance Benefits: I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

In what city and state did the **Proposed Owner** sign this application? *(City)* _____ *(State)* _____

Proposed Insured Signature _____ Date _____

Proposed Owner/Trustee Signature _____ Date _____

Owner / Trustee Name *(If other than the Proposed Insured.)* _____

Owner Title *(If applicable.) (Please print.)* _____

I agree to be bound by the terms and conditions of the current [ING Life Companies] General Agent or Producer Agreement ("Agreement"), unless I am an employee / registered representative of a Broker-Dealer and do not hold an Agreement such that this language is inapplicable. I understand that I may receive an additional copy of my agent agreement and/or current compensation schedule from the Insurer by contacting Distributor Services at 877-882-5050.

I certify that all sales materials used during this sale were approved by the Insurer. Copies of all sales materials were left with the applicant no later than the time of application. (Electronically presented sales materials will be provided to the policy owner no later than at the time of the policy delivery.) All replacement sales were made in accordance with the Insurer's corporate policy. I acknowledge that I have delivered the Important Notices to the Proposed Insured(s) or Proposed Owner.

I represent that the policy applied for is not STOLI as described in Appendix A, "[ING's Policy on Stranger-Owned or Stranger-Originated Life Insurance (STOLI).]" I represent that I am not aware that the applicant is applying for insurance coverage for a stranger as part of a STOLI arrangement and neither I nor the applicant are aware of any information that would notify the Company of the policy's use as STOLI. Neither I nor the applicant have provided any information to the Company contrary to the representations I have made and the applicant has made concerning the policy's use as STOLI. My signature also certifies that except as provided in the answers to the in force replacement questions, the proposed insured(s) / owner(s) do not own any existing life insurance or annuity contracts and no other replacement of insurance or annuity is involved in this transaction. I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

To the best of my knowledge and belief, all answers provided by the Owner and Proposed Insured in the above application are true, correct and complete.

Writing Agent / Registered Rep. Signature _____ Date _____

Writing Agent / Registered Rep. Name *(Please print.)* _____

Phone (_____) _____ E-mail Address _____

Address _____ City _____ State _____ ZIP _____

SPLIT SALES ONLY

Agent Name _____ Agent Name _____

PLEASE PROVIDE THE PROPOSED OWNER / PROPOSED INSURED WITH A COPY OF THIS APPLICATION.

EXECUTIVE BENEFITS TEMPORARY INSURANCE RECEIPT GUARANTEED ISSUE

Security Life of Denver Insurance Company
[8055 East Tufts Ave., Ste 650, Denver, CO 80237]
(the "Insurer")
Mail to:[ING Customer Service Center, Executive Benefits Department. PO Box 5065, Minot, ND 58702-5065]
Fax to: 877-275-3329; Attn:[ING Customer Service Center]

Use this receipt when submitting premium for a new case or when adding entrants to a case that is in force. Premium received without this form will be returned. Complete the list bill number and Plan Sponsor / Employer so we can identify the case. Complete all items in the chart or attach a census.

List Bill # _____ **Plan Sponsor / Employer** _____

For premium(s) received from the employer in connection with Applications on the Proposed Insured(s) listed below, the Insurer provides a limited amount of life insurance coverage for a short time while it reviews an application for life insurance. This coverage is subject to the terms and conditions set out below.

Use the space below to list each Proposed Insured. You may instead attach a copy of the group census and check here ☐.

Proposed Insured Name	Premium Allocation	Amount of Insurance
		$
		$
		$
		$
		$
		$

TERMS AND CONDITIONS

Amount of Coverage: If the Proposed Insured(s) dies while this coverage is in effect, the Insurer will pay to the beneficiary named in the Application the lesser of: (a) the amount of death benefit, if any, which would be payable under the policy and any riders if issued under the Application; or (b) $1,000,000. This coverage is subject to any limits or exclusions which would be part of the issued coverage. If for any reason the Insurer is liable for any coverage as a result of any other pending applications or temporary insurance receipts on the lives of Proposed Insured(s), the Insurer's total liability shall not exceed $1,000,000; and the $1,000,000 will be prorated among the respective coverages. There is no premium waiver coverage, or coverage for the death of any person other than the Proposed Insured(s).

Coverage begins when the following forms have been completed, signed and return to the Company: the Application(s), Consent to Be Insured (when applicable), this Temporary Insurance Receipt; and a premium has been accepted while the Proposed Insured is currently engaged in active full-time work. Active full-time work is working at least 30 hours per week in normal capacity with no hospitalizations and no absences from work due to illness or accident (except absences due to minor illnesses or accidents for no more than 5 total days during the 3-month period).

Coverage under this receipt ends automatically on the earliest of the following dates:
- Five days after a refund of premium is mailed to the Proposed Owner's address shown on the Application; or
- Five days after a notice of termination is mailed to the Proposed Owner's address shown on the Application; or
- On the day that premium is wired to the Proposed Owner's account and a notice of termination has been faxed to the Proposed Owner; or
- On the day that coverage starts under any policy resulting from the Application; or
- On the day that a policy resulting from the Application is refused; or
- 90 days after the date this form is signed.

The Insurer may send a notice or return premium terminating this coverage any time before delivery of the policy.

There is no insurance coverage under this Temporary Insurance Receipt if:
- There is material misrepresentation in the answers to any question or statement in the Application or Consent form.
- A Proposed Insured dies by suicide or intentional self-inflicted injury.
- The premium check or authorized withdrawal is not honored.
- The Proposed Insured is not currently engaged in active full-time work for the Plan Sponsor / Employer at the time the premium is accepted.

Plan Sponsor / Employer Signature _____ Date _____

Plan Sponsor / Employer Name *(Please print.)* _____ Signed at *(City, State)* _____

Title *(if applicable)* _____

Writing Agent Signature _____ Date _____

Writing Agent Name *(Please print.)* _____ Agent Phone (_____)_____

EXECUTIVE BENEFITS CONSENT TO BE INSURED

Security Life of Denver Insurance Company
[8055 East Tufts Ave., Ste 650, Denver, CO 80237]
(the "Insurer")
[ING Customer Service Center: 2000 21st Ave. NW, Minot, ND 58703]

This form is for use with employer-sponsored plans that are owned by a company, bank or trust, but not by an employee. It must be submitted with a completed master application and other required forms listed on the application instructions.

List Bill # _____ **Plan Sponsor / Employer** _____

A. PROPOSED INSURED INFORMATION *(An insured must be an employee of the Plan Sponsor / Employer, a member of the Board of Directors for that Employer, or a Partner of a purchasing Partnership.)*

1. First Name _____ MI _____ Last Name _____

2. Gender: ☐ Male ☐ Female 3. Birth Date _____

4. Proposed Insured Phone (_____)_____ 5. SSN _____

6. Proposed Insured Address _____ City _____ State _____ ZIP _____

7. Are you a U.S. citizen? ☐ Yes ☐ No *If "No," provide country of citizenship, visa type, number and expiration date (if applicable).* _____

_____

8. Driver's License Number _____ Driver's License State _____
(If you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)

B. EMPLOYMENT INFORMATION

1. Plan Sponsor / Employer Address _____ City _____ State _____ ZIP _____

2. Title _____ 3. Hire Date _____

4. Annual Salary $_____ 5. Annual Bonus $_____

C. CONSENT

If I consent to be insured, I acknowledge, understand and agree to the following:

- An Insurer, selected by the Plan Sponsor/Employer, will issue to the Plan Sponsor / Employer a life insurance policy on my life.
- The Plan Sponsor / Employer may purchase the insurance directly or through a trust established by the Plan Sponsor / Employer.
- The Plan Sponsor / Employer or trust has an insurable interest in my life.
- The Plan Sponsor / Employer or trust will apply for, own and control the insurance policy in every respect.
- Neither I nor my estate, administrators, heirs or assignees have any rights in the policy or in any policy proceeds, unless the Plan Sponsor / Employer otherwise notifies the insurer in writing.
- The Plan Sponsor / Employer or trust, or its successors, will continue to be the owner and beneficiary of the life insurance policy indefinitely, including after my employment with, or status as director of, the Plan Sponsor / Employer terminates, whenever and for whatever reason this may occur.

1. During the 90 days prior to the date this application is signed, have you (1) been employed or been a Director or Partner of the Plan Sponsor / Employer continuously **AND** are you (2) actively performing normal duties at your customary place of employment for at least 30 hours per week? . . . . . ☐ Yes ☐ No

If "No," please explain. _____

2. During the 90 days prior to the date this application is signed, have you (1) been absent from work due to illness, accident or medical treatment for either more than 3 consecutive days or a total of 5 days or more (not including vacations or holidays) **OR** (2) sought or received care or treatment (outpatient or inpatient) at any type of hospital, emergency room, or urgent care facility? . . . ☐ Yes ☐ No

If "Yes," provide medical details. _____

3. Have you used any tobacco or nicotine products within the last 12 months? . . . . . ☐ Yes ☐ No

If "Yes," give type(s), frequency and date last used. _____

☐ Yes I, the undersigned, have read and understand this Consent to Be Insured form, agree that the information contained herein is accurate and complete to the best of my knowledge and belief, and willingly choose to consent as indicated above. I also agree that the Insurer may rely upon the statements and answers in this form in determining the pricing and the issuance of any insurance policies issued on my life, and that the form may be attached to and made part of any such insurance policy. I acknowledge receipt of the Notice Regarding Information Practices.

☐ No I do not consent to have insurance purchased on my life.

Proposed Insured Signature _____ Date _____

SERFF Tracking #:	*INGD-128729544*	***State Tracking #:***	***Company Tracking #:*** *165949 APPS*

State:	*Arkansas*	***Filing Company:***	*Security Life of Denver Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*165949 Apps*		
Project Name/Number:	*165949 Apps/165949 Apps*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
AR Certification Reg 19 _SLD_.pdf Flesch Readability Certification.pdf			

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability		
Comments:			
Attachment(s):			
Statement of Variability.pdf			

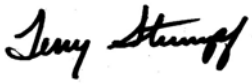
ARKANSAS

C E R T I F I C A T I O N

Re: 165949 Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance
165952 Executive Benefits Individual Application for Employer-Sponsored Guaranteed Issue Life Insurance
165956 Executive Benefits Application for Simplified Issue Life Insurance
165967 Executive Benefits Temporary Insurance Receipt Guaranteed Issue
165976 Executive Benefits Consent To Be Insured

We hereby certify that this submission meets the provisions of Regulation 19 and all applicable requirements of the Arkansas Insurance Department.

Security Life Insurance of Denver Company

By: 

Terry Stumpf
Assistant Secretary

Date: 11/15/2012

SECURITY LIFE OF DENVER INSURANCE COMPANY

FLESCH READABILITY CERTIFICATE

I certify that the forms included in this submission have been printed in not less than ten point type.

The style, arrangement and overall appearance of the forms give no undue prominence to any portion of the text of the forms.

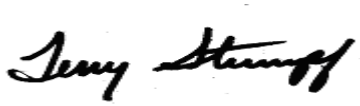
The section titles are captioned in bold face type. The layout and spacing of the forms separate the paragraphs from each other and from the border of the paper.

Unnecessarily long, complicated or obscure words, sentences, paragraphs or constructions are not used in these forms.

Flesch Scale Reading Ease Score

I have supervised the computation of the Flesch scale reading ease score of these forms, using the complete text of the forms except for headings, indexes and tabular material, and the scores are listed below.

Form Numbers		**Flesch Reading Ease Scores**
165949	Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance	50.4
165952	Executive Benefits Individual Application for Employer-Sponsored Guaranteed Issue Life Insurance	52.1
165956	Executive Benefits Application for Simplified Issue Life Insurance	50.1
165967	Executive Benefits Temporary Insurance Receipt Guaranteed Issue	53.0
165976	Executive Benefits Consent To Be Insured	51.2

Signed 

Terry Stumpf
Assistant Secretary

Date: December 6, 2012

Security Life of Denver Insurance Company

Statement of Variability
for

165949 Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance
165952 Executive Benefits Individual Application for Employer-Sponsored Guaranteed Issue Life Insurance
165956 Executive Benefits Application for Simplified Issue Life Insurance
165967 Executive Benefits Temporary Insurance Receipt Guaranteed Issue
165976 Executive Benefits Consent To Be Insured

This document will address the variability of the following factors found in the above listed form numbers.

FACTOR	RANGE OF FACTORS
Company Address	Shown in brackets as this item could change for future issues. In the event of such a change, the new address information will be referenced in this field.
ING Customer Service Center: 2000 21st Ave. NW, Minot, ND 58703	Shown in brackets as these items could change for future issues. In the event of such a change, the new name, the new address and/or contact information will be referenced in these fields.
ING Customer Service Center, Executive Benefits Department, PO Box 5065, Minot, ND 58702-5065	Shown in brackets as these items could change for future issues. In the event of such a change, the new name, the new address and/or contact information will be referenced in these fields.
ING Customer Service Center	Shown in brackets as these items could change for future issues. In the event of such a change, the new name, the new address and/or contact information will be referenced in these fields.
ING Life Companies	Shown in brackets because this item may change for future issues. In the event of such a change, the new name will be referenced in this field.
ING's Policy on Stranger-Owned or Stranger-Originated Life Insurance (STOLI)	Shown in brackets because this item may change for future issues. In the event of such a change, the new name will be referenced in this field.

SERFF Tracking #:	*INGD-128729544*	***State Tracking #:***		***Company Tracking #:***	*165949 APPS*

State:	*Arkansas*	***Filing Company:***	*Security Life of Denver Insurance Company*
TOI/Sub-TOI:	*L08 Life - Other/L08.000 Life - Other*		
Product Name:	*165949 Apps*		
Project Name/Number:	*165949 Apps/165949 Apps*		

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date	Schedule Item Status	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
12/27/2012	Replaced 01/24/2013	Form	Executive Benefits Master Application for Employer-Sponsored Guaranteed Issue Life Insurance	01/24/2013	165952_11302012_StateFiling.pdf (Superceded)

EXECUTIVE BENEFITS INDIVIDUAL APPLICATION FOR EMPLOYER-SPONSORED GUARANTEED ISSUE LIFE INSURANCE

Security Life of Denver Insurance Company
[8055 East Tufts Ave., Ste 650, Denver, CO 80237]
(the "Insurer")
[ING Customer Service Center: 2000 21st Ave. NW, Minot, ND 58703]

List Bill Number _____ **Plan Sponsor / Employer** _____

1. Is this insurance intended to be for a pension or similar tax-qualified plan? . . . . . ☐ Yes ☐ No
2. Will the policy be owned by a "Funded ERISA Plan"? . . . . . ☐ Yes ☐ No

If "Yes," please check one of the following:

☐ Tax qualified plan *(i.e., 401(k), profit sharing, defined benefit, defined contribution, HR10, 403(b))* _____
☐ Section 419/419A plan *(Specify trust name.)* _____
☐ VEBA Trust *(Specify trust name.)* _____
☐ Secular Trust

3. Is this subject to a split dollar collateral assignment? . . . . . ☐ Yes ☐ No

A. PROPOSED INSURED INFORMATION

1. First Name _____ MI _____ Last Name _____

2. Gender: ☐ Male ☐ Female 3. Birth Date _____ 4. SSN or Government Issued ID Number _____

5. Address *(PO Boxes are not permitted.)* _____

City _____ State _____ ZIP _____

6. Home Phone (_____) _____ 7. Work Phone (_____) _____

8. Driver's License Number _____ 9. Driver's License State _____
(If you do not have a driver's license, then provide government photo ID number, issuer and expiration date.)

10. Name on Driver's License *(If different than above.)* _____

11. Employer Name _____ 12. Annual Salary $_____ 13. Annual Bonus $_____

14. Employer Address _____

15. Title _____ 16. Date of Hire _____

17. Are you a U.S. citizen? . . . . . ☐ Yes ☐ No
If "No," please explain and provide country of citizenship and status. _____

18. During the 90 days prior to the date this application is signed, have you (1) been employed or been a Director or Partner of the Plan Sponsor / Employer continuously **AND** are you (2) actively performing normal duties at your customary place of employment for at least 30 hours per week? . . . . . ☐ Yes ☐ No
If "No," please explain. _____

19. During the 90 days prior to the date this application is signed, have you (1) been absent from work due to illness, accident or medical treatment for either more than 3 consecutive days or a total of 5 days or more (not including vacations or holidays) **OR** (2) sought or received care or treatment (outpatient or inpatient) at any type of hospital, emergency room, or urgent care facility? . . . . . ☐ Yes ☐ No
If "Yes," provide medical details. _____

20. Have you used any tobacco or nicotine products within the last 12 months? *(e.g., cigarettes, cigars, pipes, chewing tobacco, nicotine gum, or nicotine patches)* . . . . . ☐ Yes ☐ No

If "Yes," indicate Type _____ Amount & Frequency _____ Month/Year Last Used _____

B. PROPOSED OWNER INFORMATION *(Complete if other than Proposed Insured. If the owner is a trust, provide a copy of the full Trust document or complete the Trust Certification.)*

1. Owner Name _____ 2. Owner SSN/TIN _____

3. Owner Address *(PO Boxes are not permitted.)* _____

City _____ State _____ ZIP _____

4. Correspondence Address _____

City _____ State _____ ZIP _____

5. Relationship to Proposed Insured: ☐ Trust ☐ Other _____

6. Trustee Name *(If applicable.)* _____ 7. Date of Trust _____

C. BENEFICIARY INFORMATION *(Total percentage of primary beneficiaries shares must equal 100%. Total percentage of contingent beneficiaries' shares must equal 100%. Please use whole percents. If no percentages are listed, beneficiaries' shares will be distributed equally; however, partial percentages are not allowed so the first listed beneficiary will receive the largest whole percentage.)*

Individual as a Beneficiary *(Complete the table below.)*

Name *(First, MI, Last)*	Birth Date	Gender	SSN	Relationship	%	Beneficiary Type
		☐ Male ☐ Female				☐ Primary ☐ Contingent
		☐ Male ☐ Female				☐ Primary ☐ Contingent
		☐ Male ☐ Female				☐ Primary ☐ Contingent
		☐ Male ☐ Female				☐ Primary ☐ Contingent

Trust or Business / Corporation as a Beneficiary *(Complete the table below.)*

Trust or Business / Corporation Name	Trust Date	State of Incorporation / Domicile	%	Beneficiary Type
				☐ Primary ☐ Contingent
				☐ Primary ☐ Contingent

D. POLICY INFORMATION

1. Product Requested _____ 2. Policy Issue Date *(Month, Day, Year)* _____

3. Base Coverage $_____ *(Not including Riders - See Section E for Adjustable Term Insurance Rider.)*

4. Guaranteed Issue Version: ☐ Select or ☐ Regular 5. Rate: ☐ Unisex Version or ☐ Sex Distinct

6. Death Benefit Option: *(NOT ALL OPTIONS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)*

If no option is selected, option will default to A.

☐ A or 1 (Level) ☐ B or 2 (Increasing or Variable)

☐ C or 3 (Face Amount + Premium) ☐ D or 4 (Face Amount + Premium + Interest % _____)

7. Death Benefit Qualification Test: *(If no option is selected, option will default to Guideline Premium Test.)*

☐ Guideline Premium Test ☐ Cash Value Accumulation Test

E. RIDER INFORMATION *(Check appropriate box and enter amounts. Automatic riders are not listed below. NOT ALL RIDERS ARE AVAILABLE WITH ALL PRODUCTS OR IN ALL STATES.)*

☐ Adjustable Term Insurance Rider *(Specify rider amount.)* $ _____
(Specify total Death Benefit, including base & adjustable term rider.)
$ _____

☐ Early Cash Value Rider

☐ Guaranteed Death Benefit Rider *(An option below must be selected.)*
☐ Lifetime ☐ 20-Year ☐ To age 65 or 20 years, if later

☐ Guaranteed Minimum Accumulation Benefit Rider

☐ Waiver of Specified Premium Total Disability Rider
(Specify monthly premium - illustration required) $ _____

☐ Waiver of Surrender Charge Rider

☐ Other _____

☐ Other _____

F. BILLING INFORMATION

1. Send Premium Notices to: ☐ Employer ☐ Owner ☐ Other *(If "Other," provide name and address below.)*

2. Contact Name _____

3. Billing Address *(PO Boxes are not permitted.)* _____

City _____ State _____ ZIP _____

4. Payment Method: ☐ List Bill ☐ Other _____

5. Payment Frequency: ☐ Annually ☐ Semi-Annually ☐ Quarterly ☐ Monthly

G. IN FORCE / REPLACEMENT INFORMATION

1. Do you currently have life insurance or annuity contracts inforce or applied for? *(If "Yes," provide details below. Complete state required replacement form for Model Replacement Regulation States ONLY.)* . . . . ☐ Yes ☐ No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? *(If "Yes," complete state required replacement form and provide details below.)* . . . . ☐ Yes ☐ No
3. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? *(If "Yes," complete state required replacement form and provide details below.)* . . . . ☐ Yes ☐ No
4. Is this insurance intended to be a tax-free or 1035 exchange?. . . . . ☐ Yes ☐ No
   If "Yes," will a policy loan be carried over? . . . . . ☐ Yes ☐ No

5. For any "Yes" answer to questions 1-3, provide details regarding the policies in the chart below.

Owner Name	Insurance Company	Contract / Policy Number[1]	Account Value / Amount of Coverage[1]	Date Issued / Date Applied[1]
			$	
			$	
			$	

[1] *Include in attached census.*

H. AUTOMATIC TELEPHONE PRIVILEGES *(Complete for Variable Products ONLY)*

I understand that I may indicate below whether to allow telephone privileges to be provided to me and/or my agent / registered representative and his/her assistant. Telephone privileges allow an authorized person to call the Insurer to make certain elections and request certain transactions. The Insurer may use procedures to ensure instructions received by telephone are genuine, such as requiring forms of personal identification and tape recording phone calls. By accepting telephone privileges, I authorize the Insurer to record my telephone calls to the Insurer. The Insurer and its distributor will not be liable for any loss, damage, costs or expenses incurred in acting on telephone instructions reasonably believed to be genuine. I understand that if I do not want to authorize telephone privileges, I should not check either of the two boxes below. I also understand that once granted, such privileges will be revoked by upon receipt by the Insurer of signed, written instructions to terminate telephone privileges.

☐ I want telephone privileges.

☐ I want telephone privileges granted to my agent/registered representative and his/her assistant.

I. SUITABILITY / NEEDS ANALYSIS - VARIABLE PRODUCTS ONLY *(Completed by the Proposed Owner. Failing to provide this information will result in a delay in the issuing of new business.)*

1. Have you received a current prospectus including supplements for the variable life insurance policy? . . . . . ☐ Yes ☐ No

   Provide date of policy prospectus / supplement. _____

2. Do you understand that:
   a. The amount or duration of the policy death benefit may vary under specified conditions; **Policy values may increase or decrease with the investment experience of the variable investment options; Policy values may also increase with the interest credited in the Guaranteed Interest Division and/or the Indexed Credit Strategy, if applicable; The amount payable is not guaranteed, but is dependent on the account value and amounts owed under the policy?** . . . . . ☐ Yes ☐ No
   b. The fluctuation in values under the policy means that scheduled premium payments may not be sufficient to keep the policy in force in the event of market declines? . . . . . ☐ Yes ☐ No
   c. Personalized illustrations are based on hypothetical rates of return which may not be indicative of future investment experience of the variable investment options or of actual interest credited in the general account option(s)? . . . . . ☐ Yes ☐ No

J. POLICY BACKDATING INFORMATION

You may choose to backdate your policy up to six months (depending on state requirements). Backdating your policy may benefit you if you will become a year older within six months of the date your policy is issued. If you backdate your policy we will calculate the premium for your policy based on your "backdated" age. This could save you money in the future by allowing you to receive a lower premium. You would be required to pay the accumulated premium for the length of time that the policy is backdated. For instance, if you apply for a policy on August 1 and backdate the policy to June 1, you will be responsible for premium from June 1. This amount will be part of your initial premium payment only. Please consult your agent to determine the availability of backdating in your state and whether it is appropriate for your circumstances.

Would you like to backdate your policy? ☐ Yes *(If "Yes," review the policy backdating notice below.)*

POLICY BACKDATING NOTICE: As a policyholder, you have elected to backdate your policy, which enables you to gain benefits of lower age for the purposes of calculating cost of insurance charges on your policy.

If you choose to pay your premiums by automatic bank draft, your account will be drafted for each month that your policy is backdated unless this amount was already included in the initial premium payment. You are encouraged to obtain overdraft protection from your bank to avoid any unhonored withdrawals and associated fees.

By my signature on the next page, I acknowledge that on backdated policies, the accrued cost of insurance charges deducted from the initial premium results in the values within the policy being lower than those illustrated. **I also understand that if I choose to pay premiums by automatic bank draft, my bank account will be drafted to "catch up" my policy premiums for each month that my policy is backdated.**

K. AGENT VERIFICATION *(For Agent Use ONLY)*

Agent Name / Broker-Dealer *(Please print.)*	Agent Number	% Split	General Agent Number	General Agent Name

L. SPECIAL INSTRUCTIONS

M. ACKNOWLEDGEMENTS, CERTIFICATIONS AND REPRESENTATIONS

Acknowledgements and Agreement: By signing this application, I acknowledge and agree that:

1. **Application:** I have read this application and I agree with the statements in this application.
2. **Rescission for False Statements:** The Company may seek to rescind the life insurance coverage if it determines that any question was not answered truthfully including without limitation, financial, employment and medical information.
3. **Information Limited to Application.** The application will be the basis for any life insurance coverage issued and no information will be considered to have been given by me to the Company or authorized by me unless it is stated herein.
4. **Company's Liability for Insurance Coverage.** Unless otherwise stated in a valid Temporary Insurance Receipt, the Company will have no liability until all requirements are met, a policy is delivered to and accepted by me, there is no material change in the health of the Proposed Insured between the time of application and the time of delivery of the policy, and the first premium is received by the Company while the Proposed Insured is alive.
5. **Temporary Insurance.** If I have paid premium by check with this application, I have completed the Temporary Insurance Receipt.
6. **No Waiver by Producer.** The producer does not have the authority to waive the answer to any question in the application, to accept risk or pass on insurability, to make or alter any contract, or to waive any of the Company's rights or requirements.

M. ACKNOWLEDGEMENTS, CERTIFICATIONS AND REPRESENTATIONS *(Continued)*

7. **Application Changes.** No change in the amount, classification, age at issue, insurance plan, or benefits shown on this application will be effective unless both the Company and I agree in writing.
8. **Delivery Requirements.** If a policy is underwritten and issued as a result of this application, all required documents pertaining to the delivery of the policy must be completed and returned to the issuing company within 60 days of receipt. Otherwise, the policy will not be in force.
9. **Signature.** By signing this application, I am applying for life insurance coverage issued by the Company.
10. **Receipt of Disclosure and Forms.** I received the following disclosures and notices: Accelerated Benefit Rider Disclosure, Notice Regarding Consumer Reports, Notice Regarding MIB, Inc., and Notice Regarding Collection of Information and Information Practices.
11. **Governing Law.** The Policy shall be governed in all respects, including validity, interpretation and effect, without regard to principles of conflicts of law, by the laws of the state in which it is delivered, which shall be deemed to be the state in which this Application is executed as shown below.
12. **Jurisdiction.** Any dispute, claim, demand, controversy, action or proceeding, however characterized, relating to, arising under, in connection with, or incident to the Policy or sale of the Policy ("Action or Proceeding") shall be filed and heard in the state or federal courts located in the state in which the Policy is delivered. The state and federal courts located in the state in which the Policy is delivered shall have jurisdiction over the parties to the Action or Proceeding.

Certification. By signing this application, I certify, under penalty of perjury, that my Social Security Number/ Tax Identification Number is shown and is correct and that I am not subject to back-up withholding.

Representations. By signing this application, I represent that:

1. All questions have been truthfully answered to the best of my knowledge and belief.
2. The policy is not STOLI and I have not engaged in any prohibited conduct as described in Appendix A.
3. The Owner has an insurable interest in the life of the Proposed Insured.
4. I agree to inform the Company of any known material change in health of the Proposed Insured prior to delivery of the Policy.

Acknowledgement of Insured

As proposed insured of this policy:

☐ I acknowledge that no illustration was provided to me in connection with this application either before or at the time the application was signed.

☐ I acknowledge that an illustration was provided to me in connection with this application either before or at the time the application was signed.

I authorize the Employer listed in this application to accept delivery of the policy, to sign any illustration, and to apply for future changes on my behalf.

False or Misleading Information – Criminal and Civil Penalties / Denial of Insurance Benefits: I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

In what city and state did the **Proposed Owner** sign this application? *(City)* _____ *(State)* _____

Proposed Insured Signature _____ Date _____

Proposed Owner/Trustee Signature _____ Date _____

Owner / Trustee Name *(Please print.)* _____

Owner Title *(If applicable.) (Please print.)* _____

I agree to be bound by the terms and conditions of the current [ING Life Companies] General Agent or Producer Agreement ("Agreement"), unless I am an employee / registered representative of a Broker-Dealer and do not hold an Agreement such that this language is inapplicable. I understand that I may receive an additional copy of my agent agreement and/or current compensation schedule from the Insurer by contacting Distributor Services at 877-882-5050.

I certify that all sales materials used during this sale were approved by the Insurer. Copies of all sales materials were left with the applicant no later than the time of application. (Electronically presented sales materials will be provided to the policy owner no later than at the time of the policy delivery.) All replacement sales were made in accordance with the Insurer's corporate policy. I acknowledge that I have delivered the Important Notices to the Proposed Insured(s) or Proposed Owner.

I represent that the policy applied for is not STOLI as described in Appendix A, "[ING's Policy on Stranger-Owned or Stranger-Originated Life Insurance (STOLI).]" I represent that I am not aware that the applicant is applying for insurance coverage for a stranger as part of a STOLI arrangement and neither I nor the applicant are aware of any information that would notify the Company of the policy's use as STOLI. Neither I nor the applicant have provided any information to the Company contrary to the representations I have made and the applicant has made concerning the policy's use as STOLI. My signature also certifies that except as provided in the answers to the in force replacement questions, the proposed insured(s) / owner(s) do not own any existing life insurance or annuity contracts and no other replacement of insurance or annuity is involved in this transaction. I understand and agree that any person who knowingly provides false, incomplete or misleading information to an insurance company for the purpose of defrauding or attempting to defraud the company commits a fraudulent insurance act, which is a crime, and may be subject to criminal and civil penalties and denial of insurance benefits. Penalties may include imprisonment and/or fines.

To the best of my knowledge and belief, all answers provided by the Owner and Proposed Insured in the above application are true, correct and complete.

Writing Agent / Registered Rep. Signature _____ Date _____

Writing Agent / Registered Rep. Name *(Please print.)* _____

Phone (_____) _____ E-mail Address _____

Address _____ City _____ State _____ ZIP _____

SPLIT SALES ONLY

Agent Name _____ Agent Name _____

PLEASE PROVIDE THE PROPOSED OWNER / PROPOSED INSURED WITH A COPY OF THIS APPLICATION.